MARICOPA HEALTH SYSTEM
Count on us to care.

MARICOPA MEDICAL CENTER

DEPARTMENT OF PSYCHIATRY
DESERT VISTA BEHAVIORAL HEALTH
570 W. BROWN ROAD
MESA, AZ 85201

CONTACT: Norma Valverde, Program Coordinator
OFFICE: 480 344-2028
FAX: 480 344-2157

Clinical Clerkship/Elective/Medical Student Application ~~ (please type or print)

ROTATION REQUEST

Rotations Offered: ______________________________

______________________________ ______________________________
ROTATION TITLE (My 1st preference) INCLUSIVE DATES

______________________________ ______________________________
(2nd preference - if 1st preference is unavailable) INCLUSIVE DATES

______________________________ ______________________________
(3rd preference - if 2nd preference is unavailable) INCLUSIVE DATES

PERSONAL DATA

Name in Full (First, Middle, Last)______________________________

Social Security # ______________________________ **DOB:** ____________________

Current Home Address: ______________________________

____

Home Telephone: ____________________ **Pager:** ____________________

Fax: ____________________ **E-Mail Address:** ____________________

Emergency Contact: ____________________ **Telephone**: ____________________

EDUCATION

Undergraduate School: ______________________________

Mo/Yr to Mo/Yr: ____________________ **Degree:** ______________________________

Medical School: ______________________________

Mo/Yr to Mo/Yr (expected date of graduation)**:** ______________________________

If Foreign Medical Student, date of examination: ______________________________

CLERKSHIP

IF you have previously completed any clerkships/elective/rotations at Maricopa Medical Center, indicate rotation and inclusive dates:

ROTATION #1: ______________________ **DATES:** ______________________________

ROTATION #2: ______________________ **DATES:** ______________________________

OTHER

- **Have you ever been convicted of a felony?** ☐ **No** ☐ **Yes**
- **Have you ever been sanctioned, excluded, or debarred by the federal government from participation in healthcare programs?** ☐ **No** ☐ **Yes**
- **Have you ever been convicted of a misdemeanor that involved drugs, alcohol related offenses, or crimes of moral turpitude?** ☐ **No** ☐ **Yes**
- **If you have answer yes to any of the above three questions, please explain** ______________________________

  ____

Application Completion

- **In order for my application to be complete, I have attached the following documents:**

  ☐ **Curriculum Vitae**

  ☐ **USMLE/COMLEX/ECFMG Scores Part I & II (as appropriate)**

  ☐ **Letter from the Dean of your Medical School stating approval of this rotation and class rank**

  ☐ **Immunization Record** (TB must be current – within 12 months of requested rotation)

  ☐ **Certificates of Liability Insurance**

  ☐ **Proof of Personal Health Insurance**

  ☐ **Copy of School ID, Passport or State Issued ID Card**

  ☐ **Verification of HIPPA Training**

I hereby certify that the information I submit in this application is complete and correct to the best of my knowledge and belief (must be signed to process application)**.**

______________________________ ______________________

Applicant Signature Date

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OFFICE USE ONLY:

Coordinator Approved on: ____________ Comments: ____

Sent to Attending on: ____________ Attending Approved/Denied on: ____

Sent to GME on: ____________ GME Approved/Denied on: ________________ Sent Letter on:__________________

Department Approved Dates: _______________ Department Approval:________________________________

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